Ohio | Department of Medicaid

Testimony to the Senate Committee

Governor DeWine's Executive Budget Proposal SFY 2024-2025
Maureen M. Corcoran, Director, Ohio Department of Medicaid
April 18, 2023

Chair Dolan, Vice Chair Cirino, Ranking Member Sykes, and members of the Senate Finance Committee. Thank you for the opportunity to address you today. I am Maureen Corcoran, Director of the Ohio Department of Medicaid. I am pleased to present the Medicaid portion of Governor DeWine's executive budget proposal for SFY 2024-2025.

The Ohio Department of Medicaid (ODM) is the single state agency responsible for the administration of Ohio's Medicaid program. With a network of over 170,000 providers, Ohio's Medicaid program delivers healthcare access and related community support services to more than 3.4 million Ohioans, including children, pregnant women, adults, seniors, and individuals with disabilities, across the life spectrum. The following statistics highlight this important role in serving Ohioans:

- Over half of Ohio births are covered by Medicaid.
- More than 1.3 million children in our state are served by Medicaid.
- More than 16,500 children are enrolled and receiving specialized services through OhioRISE.
- Nearly a third of Ohio Medicaid's adult population suffers from a mental illness and about twenty five percent of children have a behavioral health diagnosis.[1]
- More than 141,000 Ohioans are served on 7 HCBS waivers; ~51,500 are served on waivers for individuals with intellectual and developmental disabilities, and ~90,000 are served on waivers for elderly, physically and developmentally disabled people.
- 46,140 Ohioans served in Nursing Facilities have Medicaid, representing 64% of all NF days.

ODM's budget proposal for state fiscal year (SFY) 2024-2025 addresses five priorities for our state:

1. Ensuring eligible Ohioans have continuous access to high-quality health care as the state resumes routine eligibility operations.
2. Preserving and strengthening access for Ohioans to behavioral health and other community-based services, focusing on those who provide direct care and services to individuals while working to address workforce shortages.
3. Continued implementation of Medicaid's Next Generation of Managed Care, including OhioRISE, the Single Pharmacy Benefit Manager (SPBM), Fiscal Intermediary (FI), and the Provider Network Management (PNM) module.

[1] Prevalence for calendar year 2021. See Ohio Medicaid Assessment Survey (OMAS) dashboard. (n.d.). Retrieved November 19, 2022, from https://grcapps.osu.edu/app/omas

4. Ensuring Ohio's mothers and children have access to the necessary programming for sustainable healthcare they need, connecting pregnant mothers to evidence-based resources that improve birth outcomes, seeking to eliminate disparities that negatively impact the health of Ohioans we serve.
5. Continuing progress on priority policy initiatives approved in HB 110 of the 134th General Assembly.

Budget Overview

Medicaid: A Shared State/Federal Health Care Program

Overview of Funding

Ohio Medicaid's budget across all agencies is projected to be $41.6 billion (all funds) in SFY 2024 and $43.8 billion in SFY 2025 (all funds).

Medicaid is a joint federal-state program financed through a payment arrangement called the Federal Medical Assistance Percentage (FMAP). This means that the federal government will match state spending on healthcare at a certain percentage. In Ohio, that FMAP rate is approximately 64%. Since the majority of program funding comes from federal sources, Ohio is able to alleviate pressure on the state general revenue fund by maximizing non-GRF resources such as franchise fees and local funds from sister agencies like the Department of Developmental Disabilities (DODD). This is represented in Figure 1, where $1 of state share spending is expected to purchase $5.91 worth of services for Ohioans in SFY 2024.

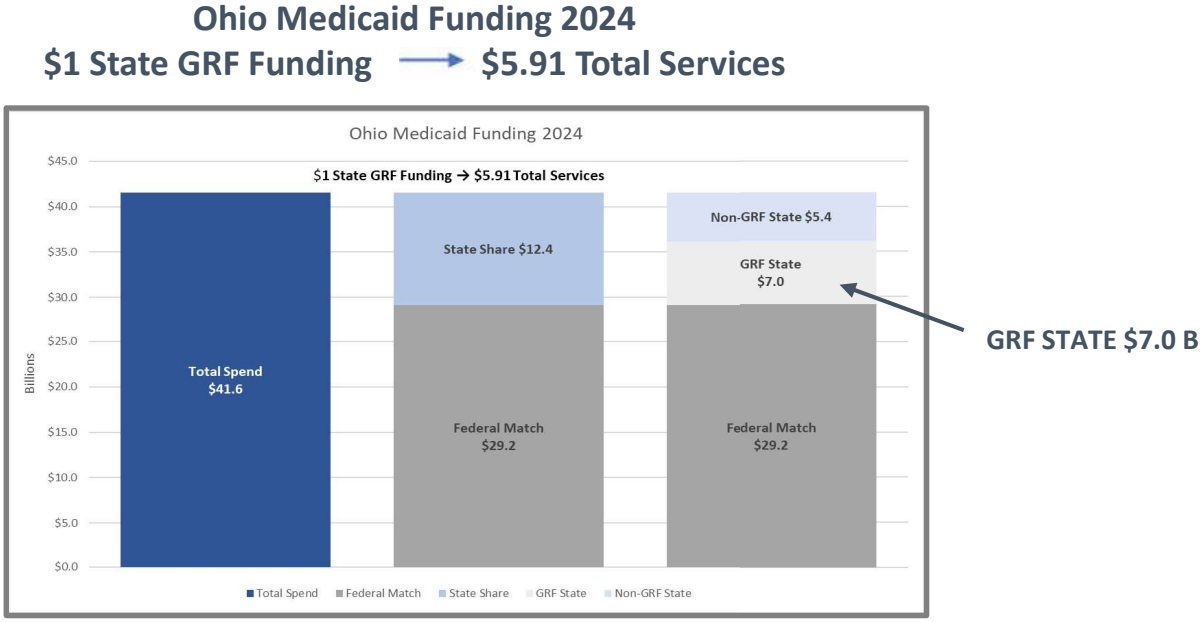


***Figure 1**: In SFY 24, the Medicaid program is 70.2% federally funded*

Medicaid as a Component of Various Systems of Services

Of these totals, ODM-administered components of the Medicaid program make up 89%, while the balance is administered by seven other state agencies – DODD, Job and Family Services (JFS), Mental

Health and Addiction Services (MHAS), Health (ODH), Aging (ODA), Education (ODE), and the Pharmacy Board – as well as several local public entities. The figure below shows the breakdown of the percentage of Medicaid funding by agency.

Figure 2

Medicaid across the life spectrum

Medicaid % by Department	
ODM	81.1%
DODD	10.3
MHAS/ODM	5.66
AGE/ODM	2.14
JFS	0.8%
Health. ODE, Pharm Bd	0.1%

- More than 1.3 million children in our state are served by Medicaid.
- Over half of Ohio births are covered by Medicaid.
- More than 16,500 children are enrolled and receiving specialized services through OhioRISE.
- Nearly a third of Ohio Medicaid's adult population suffers from a mental illness and about twenty five percent of children have a behavioral health diagnosis
- More than 141,000 Ohioans served on 7 HCBS waivers;
  - ~51,500 IDD and
  - ~90,000 elderly, physically and developmentally disabled
- 46,140 Ohioans served in Nursing Facilities (64% of all NF days)

SFY 24-25 Financial Drivers: Inflation, Shifting Workforce Dynamics and Continuous Eligibility Coverage

Throughout the SFY22-23 biennium, Ohio faced increased economic, medical, and workforce pressures. Inflation is impacting individual's and business's cost to operate, at a time consumers are already struggling with high costs associated with food, transportation and household expenses. The last couple of years have highlighted the significant challenges of supporting the healthcare workforce and assuring basic health and safety for those served.

In March 2020 in response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA) which provided states with an additional 6.2 percentage point increase in their federal share of Medicaid funding, also known as enhanced FMAP (eFMAP). This increase amounted to approximately $350 million per quarter, through the end of March 2023. The eFMAP was contingent on a "maintenance of effort" (MOE) provision in the FFCRA. The MOE provision (otherwise known as continuous coverage) required states to maintain eligibility for individuals served by Medicaid throughout the federally declared Public Health Emergency (PHE) effectively prohibiting termination of coverage except in limited circumstances (i.e., moved out of state, death, requested to be removed).

However, in December 2022, Congress enacted the Consolidated Appropriations Act, 2023 (CAA), officially delinking the continuous coverage provision from the PHE and phasing out the eFMAP

throughout the remainder of 2023. The table below indicates the increased percentage and total actual and expected funding through the end of this calendar year. The Biden Administration recently notified states that the PHE will end on May 11th.

Figure 3

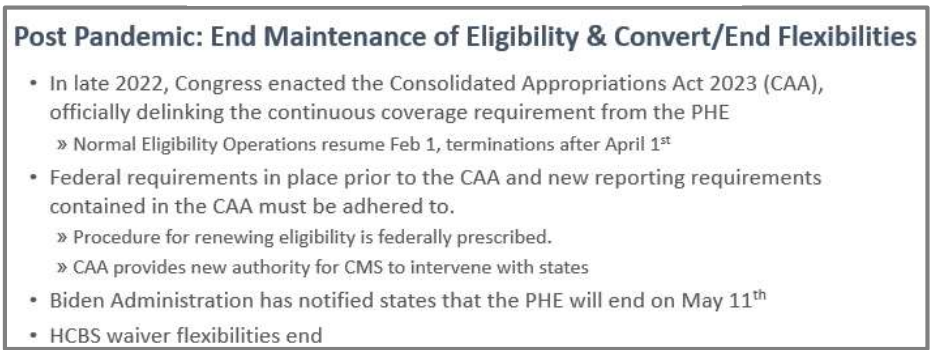


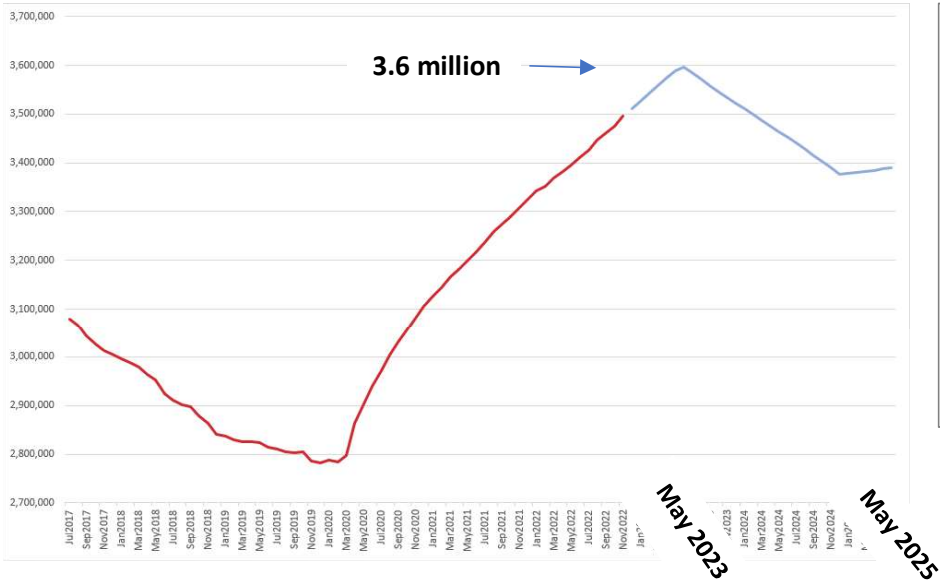
Figure 4
Enhanced Federal Funds

Time Period	No. Calendar Quarters	Enhanced Matching Rate (Percentage Increase)	Enhanced Federal Funds Received
Jan. 1, 2020 – Mar. 31, 2023	**13**	**6.20%**	**$4.54 Billion**
Apr. 1 – Jun. 30, 2023	**1**	**5.00%**	**$310 Million**
Jul. 1 – Sept. 30, 2023	**1**	**2.50%**	**$157 Million**
Oct. 1 – Dec. 31, 2023	**1**	**1.50%**	**$85 Million**
Jan 1,2020 – Dec.31, 2023	**16**	**Total**	**$5.1 Billion**

Medicaid Caseload and Eligibility

After nearly three years of Medicaid caseload increases due to the continuous coverage provision, recent action by Congress allows states to return to routine eligibility operations. As of this writing, a net of 761,000 newly eligible individuals have enrolled in Medicaid, a 27.3% increase since February 2020. The total caseload as of January 2023 is 3.55 million. ODM projects that at its peak, caseload will top out at 3.6 million members.

Figure 5
Medicaid Caseload SFY 2018-2025
Executive Budget Submission SFY 24-25



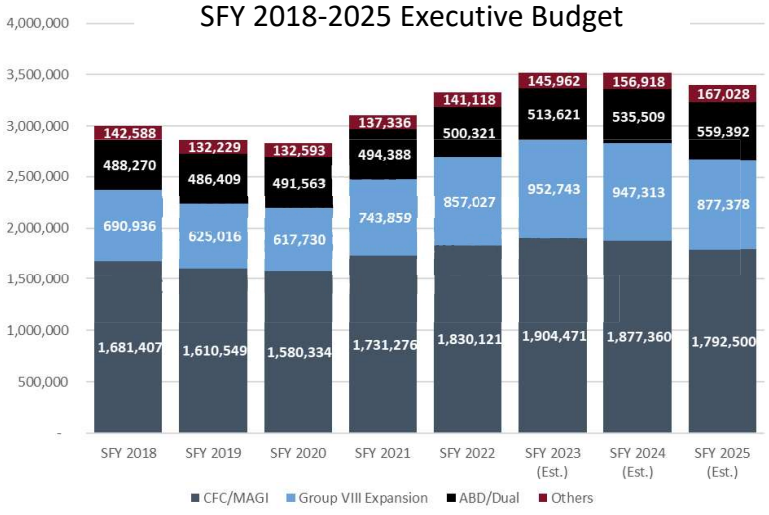
--As of Jan. 31st case 3.55 Net 761,000 = 27.3% increase since Feb20.
--Decline after 4/1 terms.
--ODM: Peak 3.6m@May 12 mo. process; 18 mo. decline in caseload. Project decrease of 220,000 (or 27% of the addl. 800,000). LSC analysis: overall length and end of the decline same, but LSC peak is 41k below 12/22.

LSC LOWER BY 0.8% OR $512M. LSC SFY 24 (-1.3%) =$405M SFY 25 (-0.3%) =$106M

PUNCHLINE: ODM, LSC & JMOC ACTUARIAL PROJECTIONS ARE GENERALLY IN AGREEMENT W/ SOME NUANCED DIFFERENCES RE: THE PEAK.

As disenrollments begin, ODM anticipates the biggest caseload declines to occur within the Group VIII and CFC populations, as these populations are the most sensitive to economic fluctuation. In contrast, we expect the aged, blind, and disabled (ABD) and dual eligible (those eligible for Medicare and Medicaid) populations to remain steady.

Figure 6
Medicaid Caseload by Aid Group
SFY 2018-2025 Executive Budget



Other

ABD/Duals

Group 8 Expansion

CFC/MAGI

Figure 7
Medicaid Caseload by Aid Group
Executive Budget

Average Monthly Caseload								
SFY	**CFC Adults**	**CFC Children**	**Expansion**	**ABD Adult**	**ABD Children**	**Dual Eligible**	**Others**	**Total**
2023	604,639	1,299,833	952,743	197,446	52,458	263,716	145,962	3,516,796
2024	588,015	1,289,345	947,313	200,341	53,849	281,318	156,918	3,517,100
2025	541,069	1,251,431	877,378	203,415	55,285	300,692	167,028	3,396,298

Caseload Considerations: Why Medicaid Caseload Will Not Return to 2020 Levels

- Pre-Pandemic Economy & OBM and National Economists are predicting a mild recession in CY 2023
  Right before the pandemic, the economy was coming off a decade of economic growth, with historical levels of employment, improving labor force participation, and low inflation. Medicaid caseloads had been in decline for 35 consecutive months. While the unemployment rate has rebounded, labor force participation has not recovered to February 2020 levels. Additionally, national and state economist are predicting a mild recession to occur at some point in 2023. Given that, and the fact that Medicaid is countercyclical, we would expect then to see an uptick in enrollment.
- CMS/Federal Requirements re: procedures, repeated notifications, and appeal requirements
  ODM must follow all federal requirements related to all eligibility processes and reporting.
- Pressures/Reductions in Commercial Insurance
  Continuing trends in the overall commercial and employer-sponsored insurance market added pressure to families. In 2020, nearly 60% of employees with employer-sponsored insurance had a high-deductible plan. From 2015-2021 the prevalence of employer sponsored insurance for working age adults in Appalachia dropped by 5.2%; impacting roughly 100,200 adults.
- "Woodwork Effect"
  There is always a portion of the population who is "eligible" for Medicaid but never enrolls. As a result of the pandemic and the continuous coverage provision, new enrollments to Medicaid continued throughout the pandemic.
- County Challenges
  Administrative efficiencies and additional funding resources have been invested to assist counties, but workforce challenges and turnover have impacted counties, as with the rest of the economy.
- Aging of Ohio's Population
  Ohio's population is growing increasingly older, putting upward pressure on overall caseload.

Returning to Routine Eligibility Operations

ODM has been preparing for the return to routine eligibility operations and has worked tirelessly to set our county partners up for success. Additionally, Ohio submitted its required plan and has been in ongoing discussions with CMS. In my testimony to the full committee, I provided more detail about the unwinding requirements and ODM's activities to prepare.

We have also provided detail on our unwinding plan in our whitepaper resuming routine eligibility operations which can be found here.

For the subcommittee I'd like to highlight a few things about the unwinding. First, recall that HB 45 of the 134th General Assembly appropriated $30 million in dedicated county funding ***solely to process Medicaid renewals and disenrollments*** as Ohio returns to routine eligibility operations. In order to monitor performance ODM has developed a series of dashboards that break down progress at the county level giving detailed insight into the state's overall progress. The dashboards will be made available publicly soon.

Second, recall that HB 110 required ODM to contract with a vendor to identify those who are "likely IN-eligible" for the program. PCG began their work on February 1st, as we began the unwinding. Following the ex-parte review, PCG is screening a significant number of data sources, roughly seventeen data bases, and identifying those individuals who are "likely ineligible". These are sent to the counties, as priority cases for follow up. This will allow the counties to efficiently process cases starting with those most likely to result in a disenrollment.

Third, it is also important to note that CMS was given additional temporary authority in the Consolidated Appropriations Act to ensure state compliance with federal Medicaid redetermination requirements. Some of the actions CMS can take against states include:

1. Withholding Federal Financial Participation (FFP)
2. Initiating corrective action plans
3. Imposing civil monetary penalties
4. Requiring state to stop renewals or reinstate coverage for individuals deemed inappropriately disenrolled.

Fourth, the procedural detail that is federally required is significant. For example, in order to remain in compliance, data used in the determination must be less than three months old, states must not terminate more than one-ninth of their cases in a single month. States must also not overly rely on procedural terminations but rather must take certain actions to obtain up-to-date addresses and attempt to contact individuals through multiple modalities—note just through the mail. As detailed as these requirements seem, this is precisely the level of detail that CMS is focusing on.

Fortunately, as detailed in our white paper, our aggressive preparation efforts are enabling us to resume normal operations as efficiently as possible while meeting these new clarifications of federal requirements.

Removing Barriers to Meaningful Employment

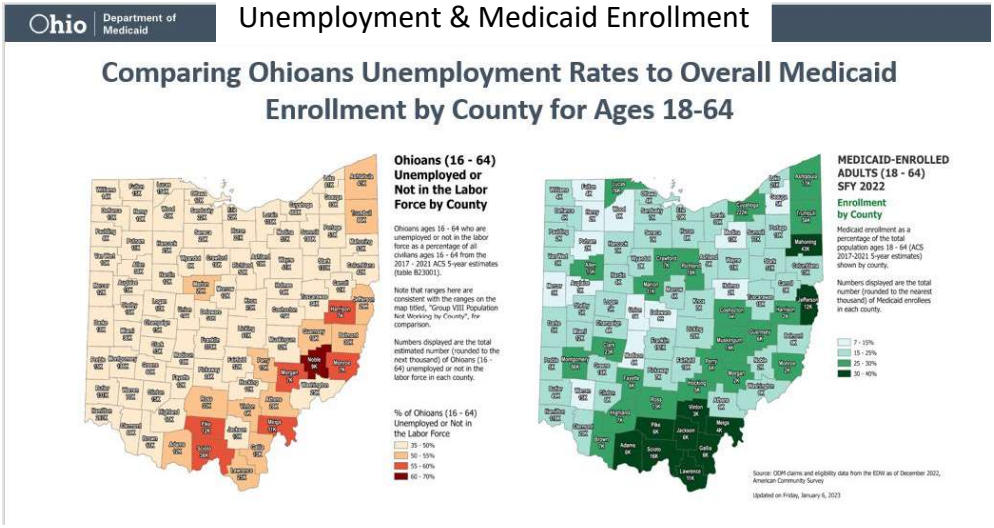
A Look at the Working Population Within Medicaid

The figure below tells a clear story; the pattern of unemployment in Ohio is very similar to the concentration of Medicaid enrollment. It makes sense, both from an economic perspective as well as the absence of jobs with decent health insurance coverage. In Appalachia, from 2015 to 2021, there

was a 5.2% decline (100,187 adults) in the prevalence of employer sponsored insurance for working age adults. See Appendix 1 for a full-size copy of this slide.

Figure 8

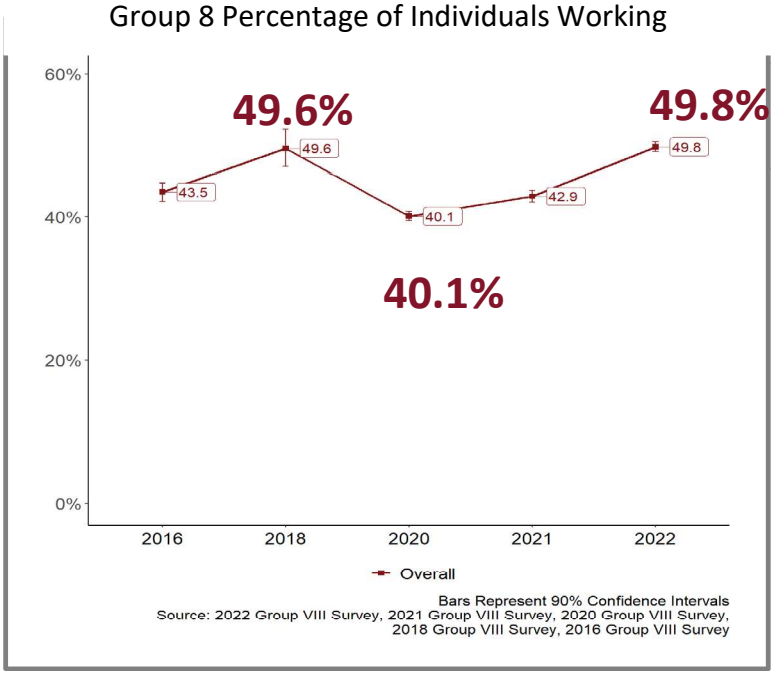
Unemployment & Medicaid Enrollment



In the 2021 Ohio Medicaid Assessment Survey (OMAS), 41.6% of the Medicaid population ages 19-64 were working. These workers were more likely to have been at their job for a shorter duration than higher income workers, suggesting elevated levels of job insecurity among low-income workers, particularly if there is an economic slowdown. More recent data from our Group VIII survey, shown below, demonstrates the Group VIII population as having returned to its pre-pandemic percentage of work participation in 2022, most commonly in industries like food service, healthcare, and retail.

Figure 9

Group 8 Percentage of Individuals Working



ODM has performed a detailed data analysis of the Medicaid population regarding work and barriers to employment. In the coming days we will release a more detailed summary of the finding. Overall, Medicaid-enrolled individuals face more health and social barriers to employment. Some key findings include:

- More self-reported "mentally distressed" days
- Higher rates of chronic conditions
- More than 40% of Group VIII and CFC (the populations most likely to be able to work) have a behavioral health diagnosis
- The percentage of the newly enrolled Medicaid individuals since the pandemic are just as likely to be working as those who were enrolled prior to the pandemic
- 76.4% of Group VIII individuals with access to employer-sponsored insurance found it unaffordable
- Medicaid-enrolled individuals reported higher rates of having difficulty affording food and housing
- Medicaid-enrolled individuals who were previously incarcerated face additional barriers to employment such as background checks

Increased Use of High Deductible Health Plans (HDHP)

In recent years, high deductible health plans (HDHPs) have risen in popularity. In 2020, 52.9% of American workers with private insurance had a high-deductible health plan.[2] This is significantly higher than in 2015, when that percentage was 39.4%. HDHPs allow workers to pay less in advance on their premiums for a health insurance product they may not use, giving them more control over their healthcare spending. However, while they may be useful tools for individuals who are higher income and overall healthier, they are often more expensive and burdensome for less healthy workers with lower incomes. Consider the below comparison as outlined by Value Penguin's findings regarding HDHPs.

Figure 10

High Deductible Health Plan Example

	Person A- HDHP	**Person B**
Annual premium	$2,500	$3,500
Deductible	$5,000	$2,000
Medical expenses	$5,000	$5,000
Total costs (premium and deductible costs)	**$7,500**	**$5,500**

While both individuals incur the same medical expenses, Person A (with the HDHP) pays more overall than Person B. Moreover, this higher expense can prove insurmountable and cost-prohibitive to lower wage workers who already experience increased job instability increasing their chances of returning to the Medicaid rolls ("churn") particularly in the event of a recession.

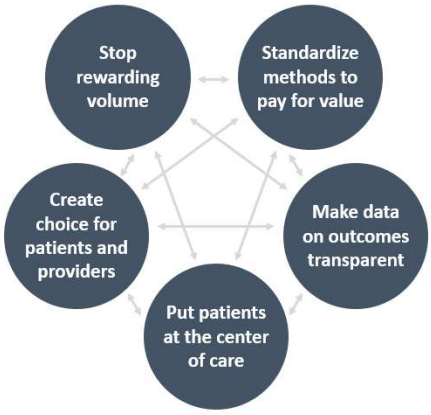
Value Based Competition: Improving Health Outcomes and Cost Containment

Immediate Efforts and a Longer-Term Status Report

Barriers such as unaffordable private insurance, health concerns, and housing and food security are all factors that prevent people from working or obtaining higher wages. They also increase the likelihood that people will enroll in Medicaid. ODM is working to address these barriers in a number of ways including:[2]

- Implementing more comprehensive social determinants o Next Generation program, managed care contracts
- Collective work--all of the MCEs working together- -with community-based organizations to develop interventions that will target underlying challenges to improve the health of individuals.
- Implementation of a voluntary work program and a dedicated Ohio Means Jobs portal to connect Medicaid individuals to direct care jobs
- Connections to HB 45 programs designed to lower costs to obtaining behavioral health workforce credentials and training
- Continuing to grow programs such as OhioRISE to change the trajectory for several medically complex multi-system kids

Figure 11
Value Based Competition: Quality & Cost Containment



Value-Based Competition: A Longer-Term Perspective

As a status report to the General Assembly, the statutory framework found in the JMOC statute is a useful starting point; addressing outcomes, transparency, cost effective service, equity, moving to value-based payment models. The Medicaid Director is required to do all of the following. Please see Appendix 2 for a review of the following areas and the specific initiatives underway and proposed for SFY 24 and 25 to address these areas.

"*Achieve the limit in the growth rate of the per recipient per month cost of the medicaid program by doing all of the following: (ORC 5162.70 (B)(2) & (3))*

- *(a) Improving the physical & mental health of medicaid recipients.*
- *(b) Providing for medicaid recipients to receive services in the most cost-effective & sustainable manner.*
- *(c) Removing barrriers that impede medicaid recipients' ability to transfer to lower cost, and more appropriate services, inc. home & community-based services*
- *(d) Establishing medicaid payment rates that encourage value over volume & result in medicaid services being provided in the most efficient & effective manner possible.*
- *(e) Implementing fraud/ abuse prevention & cost avoidance mechanisms to the fullest extent possible*
- *(3) Reduce the prevalence of comorbid health conditions and mortality rates of medicaid recipients.*
- *(4) Reduce infant mortality rates among medicaid recipients."*

[2] Figure 11. Harvard Business Review. Leemore S. Dafny and Thomas H. Lee. "Healthcare Needs Real Competition". December 2016.

Medicaid has and is doing a lot in these areas. However, despite these efforts, there are limits to what we can do in the Medicaid program. We can do little to make private insurance more affordable, but we can identify the barriers to upward mobility and share them with our partners in the General Assembly as you continue your budget deliberations.

Next Generation of Medicaid Managed Care Status Update

Phase 3 started on February 1st

Ensuring the vision of the Next Generation of managed care is carried out and meets population health, care coordination and person-centric, business transformation objectives will require continued refinement and focus through SFY24-25.

DeWine Administration Priorities: Focus on the Individual and the Next Generation of Managed Care

Shortly after taking office, Governor DeWine asked ODM to redesign the state's healthcare program, bringing high quality affordable care that supports this administration's priorities for children and families. In response, ODM worked with the General Assembly and developed a bold new vision, one that focuses on the individual and not just the business of managed care. The result is the Next Generation of Medicaid Managed Care which represents the first structural change to the program in 15 years. With extensive stakeholder feedback and building on the federally required modular replacement of MITs, this major overhaul is composed of five components:

- OhioRISE (Resilience through Integrated Systems and Excellence)
- Single Pharmacy Benefit Manager (SPBM)
- Centralized Credentialing
- Seven New Medicaid Managed Care Plans
- Fiscal Intermediary (FI)

The roll-out of Next Generation was planned in three stages as shown below:

Figure 12

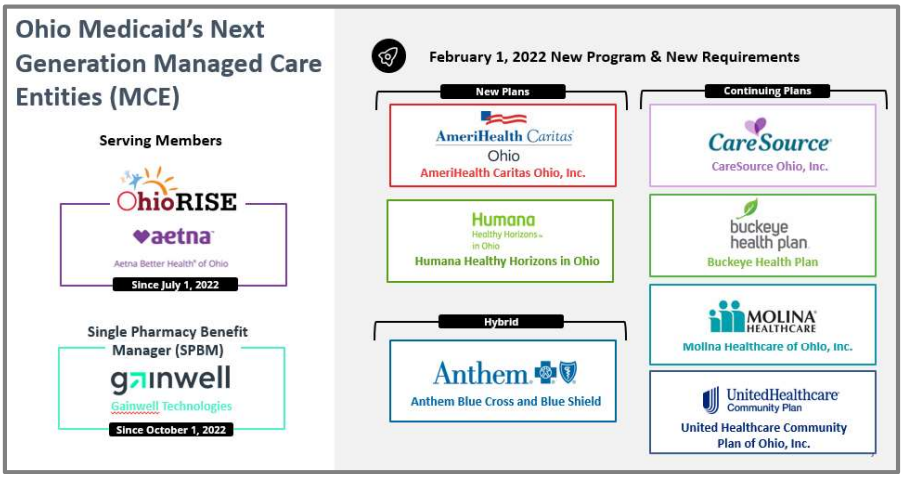
Stages of Implementation

OhioRISE, stage one of the launch, is a specialized behavioral health managed care program that aligns with the federal Family First Prevention Services Act (FFPSA) by prioritizing youth in the care of public children services agencies emphasizing prevention, early intervention and evidence-based practices for children and families. Although it is new, we expect OhioRISE to play a key role in addressing the needs of youth who could be better served in their homes rather than in out-of-home care (foster home, residential facility) hereby avoiding the heartbreaking stories we have all heard from families across this state regarding custody relinquishment. More than 16,000 multi-system children and high-risk youth can now access necessary behavioral health services and supports through coordinated community care.

Stage Two of the launch, Ohio's SPBM, fulfills a 2019 Ohio legislative mandate to bring transparency and accountability to the billion-dollar pharmacy benefit. The SPBM, operated by Gainwell Technologies, addresses years of concerns by pharmacies and stakeholders regarding obscure reimbursement methodologies and conflicts of interest that allegedly diverted profits to legacy managed care organization pharmacy programs. With the SPBM, members have access to more than 2,600 pharmacy locations, and for the first-time, consistently have a choice of specialty pharmacies to access medications that require extra care to treat conditions such as cancer, hemophilia, and other rare diseases.

The SPBM's pharmacy pricing method is fair, transparent, and predictable. It is based on evidenced-based costs Ohio pharmacies incur and is audited by the contractor who developed and maintains the National Average Drug Acquisition Cost (NADAC) pricing benchmark for CMS. Moreover, the new structure gives ODM the tools needed to better meet member health and wellness needs.
In our commitment to reduce provider administrative burdens in the new program, the Stage Two implementation also introduced elements of Ohio Medicaid Enterprise System (OMES), including centralized credentialing through the new Provider Network Management module. By moving the role of credentialing in-house here at the department, providers no longer need to understand or comply with requirements or processes unique to each managed care plan. As a result, centralized credentialing improves provider revenue cycles, and lowers credentialing costs for hospitals, facilities, providers, and practices.

Figure 13



New Next Generation Program

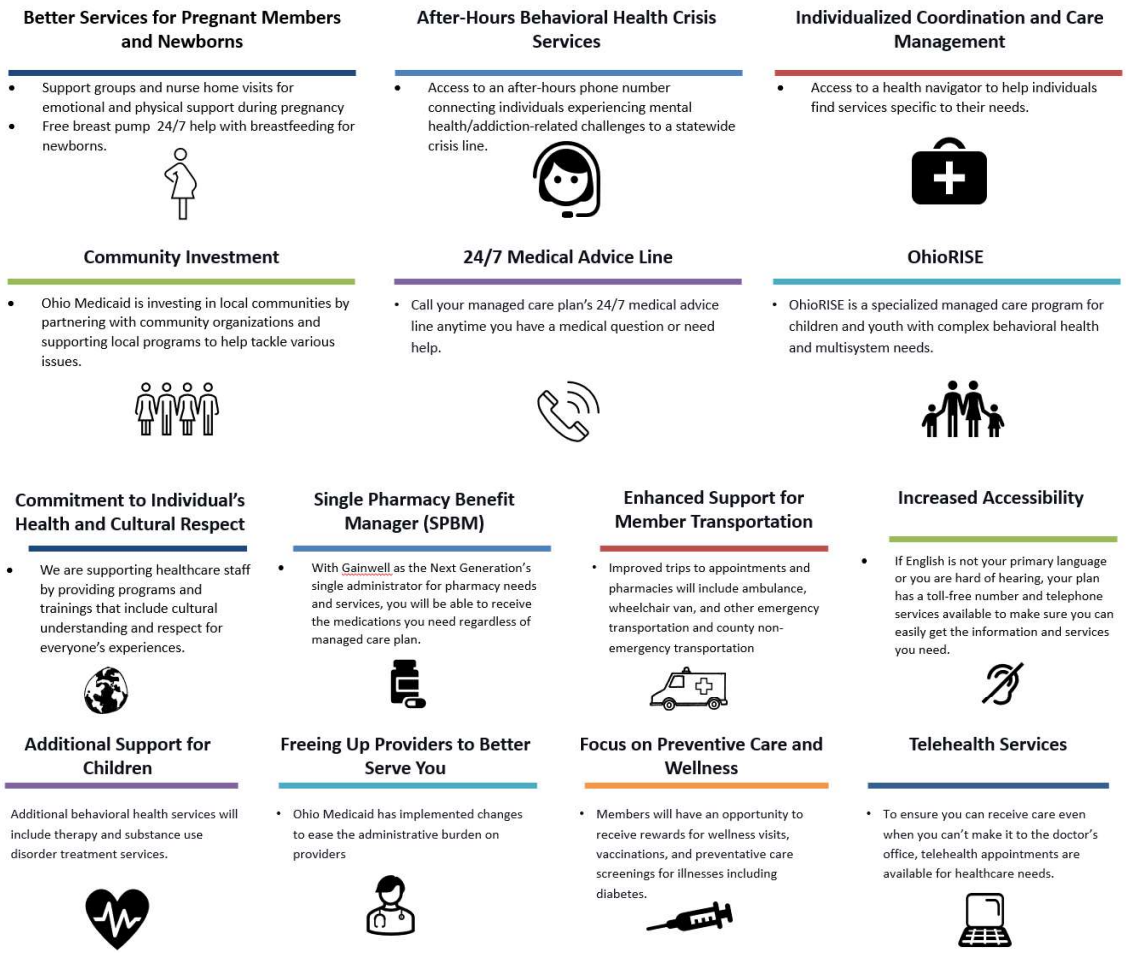
Stage 3 is the initiation of the new Next Generation program requirements, operating under significantly enhanced quality and population health management requirements. ODM is pleased to partner with AmeriHealth Caritas, Anthem, Buckeye Health Plan, CareSource, Humana Healthy Horizons, Molina Healthcare, United Healthcare Community Plan and OhioRISE Aetna Better Health.

Community Investment, Quality Improvement and the Science of Population Health: All the Ohio Medicaid Next Generation managed care entities are committed to improving member wellness through the science of population health and the practice of collective impact. New quality strategies are well underway, an unexpected benefit of the PHE with the incredible efforts of the plans. Using a population health management approach, disparities and opportunities for building health equity are identified when analyzing population data. Community engagement and listening to the "voice of the customer" are cornerstones of this first in the nation, cutting edge approach.

The following are just a few of the other changes in the Next Generation program to help address individual's healthcare needs:

Figure 14

Key Next Gen Program Improvements



Significant IT Systems Implementation: Ohio Medicaid Enterprise System (OMES)

Stage 3 is also the initiation of new functionality as part of a comprehensive effort to modernize ODM's management information systems – OMES. So, what does this all mean? OMES is the modernized replacement of most functionalities in the Medicaid Information Technology System (MITS) and other supporting systems. These information system changes were made in direct response to new CMS requirements for a more "modular" system. OMES is made up of all the systems that are used in the delivery of Medicaid services, and new business capacity including **Provider Network Management (PNM), Single Pharmacy Benefit Manager (SPBM), Fiscal Intermediary (FI) and Electronic Data Interchange (EDI)**.

How do these changes benefit Ohio Medicaid providers? Simply, these initiatives emphasize an improved provider experience by providing transparency and visibility for care and services. Additionally:

- This transition will reduce administrative burden for providers and enable providers to focus on the more meaningful and important work of providing care to members.
- OMES will serves as a single point of entry for all provider credentialing, claims, member eligibility requests and more.
- **Minimizing** missing claims, delays in claims submission, and delayed payments
- Making the claims process more **transparent** and **efficient** by limiting submission and communication of status to one single portal regardless of the MCE involved.
- Enabling **increased ODM oversight** of MCEs and ability to identify and address trends by providing ODM with consistent access to claims and prior authorization request data.

Bold Beginnings, New Children's Cabinet Agency and Other Children's Initiatives

Bold Beginnings

Since taking office, Governor DeWine has committed to ensuring that Ohio is the "best state in the nation to start and raise a family".

On September 30, Governor DeWine announced - Bold Beginnings – a gateway to early childhood resources. The initiative aims to remove barriers to healthcare, ease financial burdens, and support parents and families, and since Ohio Medicaid covers more than half of births in the state each year, we are a key partner in implementing Bold Beginnings.

As part of the Bold Beginnings package, ODM's budget proposes to:

- **Increase eligibility for pregnant women and children up to 300% of the federal poverty level**. For a single, expectant mother, the income limit will be $59,160 per year and for a family of three, that's up to $74,580 a year. This will allow more working families to access prenatal, labor, delivery, post-partum, and preventative care, as well as well-baby visits and other care

for the youngest Ohioans, without the financial stress that accompanies major medical care. Earlier this year, at the direction of the General Assembly, Ohio expanded access to postpartum women by allowing new mothers to continue receiving coverage for up to one year after giving birth.

- **Expand healthcare coverage for privately adopted youth who have special healthcare needs**. Governor DeWine will work with the legislature to allow comparable access to Medicaid for privately adopted youth, reducing economic barriers for potential adoptive families. Ohio will seek federal approval to allow children with special health care needs adopted through private agencies to be eligible for Medicaid coverage, even if their adoptive parents have private insurance.

- **Create a pathway to safe, secure housing for more struggling and new mothers**. Innovative pilot programs such as Healthy Beginnings at Home, which connects pregnant women and new mothers with housing and wrap-around supports, holds promise for demonstrably reducing infant mortality and improving birth outcomes. Ohio will pursue federal approval to increase the scale of this program to assist pregnant women and families who are struggling to find stable housing.

- **Complete implementation of Medicaid's Maternal and Infant Support Program (MISP).** MISP was created by listening to and understanding the challenges facing Ohio families, incorporating best practices, and evaluating a wide range of stakeholder strategies. MISP advances innovative and clinically sound policies and payment reforms to improve the lives of moms and babies across Ohio. As adopted in the last biennial budget, MISP has expanded post-partum Medicaid coverage to 12 months for new moms, introduced new coverage for nurse home visiting, expanded access to breastfeeding and location consulting supports, provided new opportunities for women to participate in group pregnancy learning, and launched ODM's new Comprehensive Maternal Care program. MISP is supported by Medicaid's work on the electronic Pregnancy Risk Assessment Form, which helps providers determine if state or community assistance is needed to provide stable housing, home visiting, nutrition, and education, to contribute to a healthy, stable environment, ultimately leading to improved outcomes for mom and baby.

  In the coming biennium, ODM will complete implementation of additional MISP services, including coverage for doula care and an innovative approach to co-located care for moms with substance use disorders and infants with neonatal abstinence syndrome.

New Department of Children and Youth

The Governor's budget emphasizes supporting families to ensure that every child has a strong foundation for life. It takes the bold step of creating a new cabinet-level agency, the Department of Children and Youth (DCY), to place a greater focus on improving our communities for children and families. This new department will consolidate programs currently housed across six agencies,

including the Departments of Job and Family Services, Education, Health, Developmental Disabilities, Medicaid, and Mental Health and Addiction Services.

Additional Children's Initiatives

In addition to completing the maternal and infant work described above and revisions to the Applied Behavioral Analysis (ABA) service for youth with autism, this budget proposes to expand services in the Medicaid School Program to a broader group of children with disabilities. This policy change would help schools draw down additional federal dollars for services provided, at no cost to the state's GRF.

Long Term Services & Supports Priorities for SFY 24-25

The Ohio Revised Code directs Medicaid to remove barriers that impede Medicaid recipients' ability to transfer to lower cost, and more appropriate, Medicaid services, including home and community-based services (ORC 5162.70).

The first chart below provides an overview of those served in Ohio's home and community-based services waivers. The second chart below shows the progress we have made over the years toward rebalancing our long-term care system. However, as the chart shows, we have begun to plateau, and many individuals on Medicaid have identified several barriers to these lower cost services that often make them unattainable.

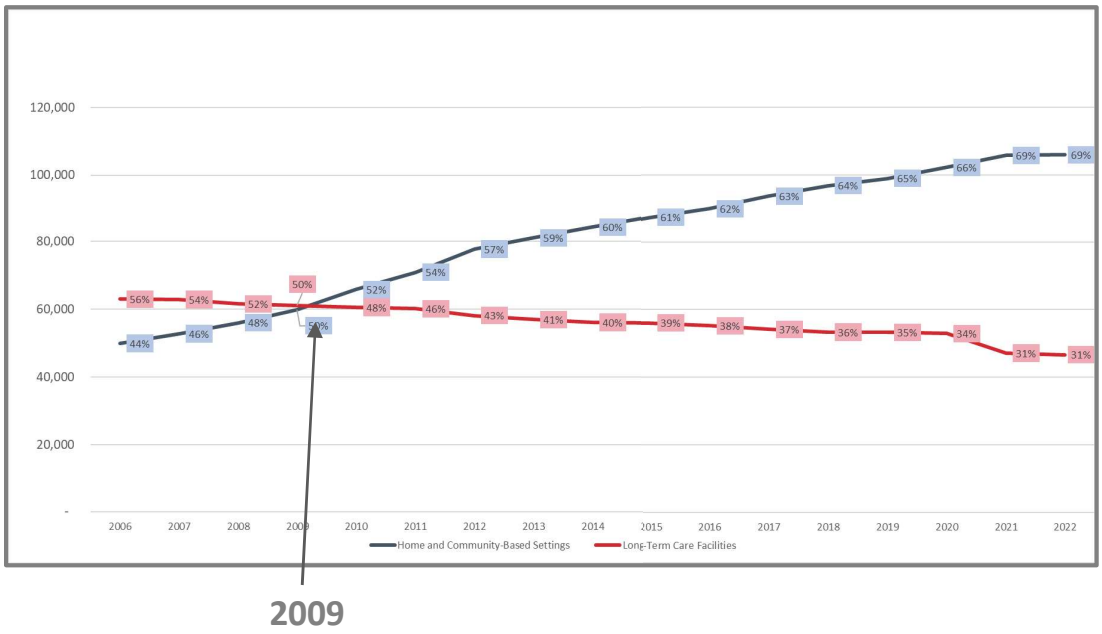
Figure 15
Home and Community Based Services
Who Medicaid serves today

	Individuals Who are Intellectually and Developmentally Disabled (DODD waivers)			Individuals Who are Elderly, Physically & Developmentally Disabled (ODM & ODA waivers)			
Names of the Waivers →	**Individual Options**	**Level One**	**Self**	**My Care**	**Ohio Home Care**	**Passport**	**Assisted Living**
Capacity # People	28,300	19,766	3,600	38,262	10,212	37,863	5,583
Total 141,586	Total 51,666			Total 89,920			
Ave. Cost of Waiver	$65,810	$11,400	$14,780	Mgd Care	$17,220	$10,700	$11,587

Figure 16

Rebalancing Ohio's Community & Institutional Service Capacity

Percentage of Individuals Receiving LTSS in **FACILITIES** & **HCBS SETTINGS** SFY 2006 -2022



In addition to the workforce issues discussed in more detail below, the following policy changes are planned to increase self-direction, enable the greatest degree of independence in community living for every individual, address program inefficiencies and misalignment, and improve care coordination for those with complex needs.

- **Increasing SELF DIRECTION** to the ODM Ohio Home Care waiver
  - » This helps addresses workforce challenge
  - » Consumers and advocacy organizations have been clamoring for this
- **MyCare Conversion**
  - » Must be completed by the end of calendar year 2025
  - » Redesign will improve care coordination and attention to behavioral health needs.
- Adding the **Structured Family Care** waiver service to ODM waiver
  - » Payments to the family caregiver
  - » Specifically targets caregiver support to avoid unnecessary institutionalization.
- Adding **Remote Monitoring** to ODM/ODA waivers
- **Additional waiver reforms** to increase efficiency and effectives of waiver services, including case management alignment.

Economic Realignment of Ohio's Direct Care Workforce

See Appendix 3 for rate calculator and rate information

More than 170,000 providers across Ohio serve Medicaid members, from large hospital or nursing home companies to community mental health agencies and independent providers of in-home

services. The partnership between Ohio's Medicaid agencies (ODM, DODD, Ohio MHAS, and ODA) and its network of providers is critical to ensuring reliable and timely access to care that improves quality of life, supports recovery and independence for individuals enrolled in the program, strengthens families, and sets Ohio's children and youth on the best possible path so they can grow up to lead healthy and successful lives.

Staffing challenges that existed across the spectrum of health care providers prior to the COVID-19 pandemic were exacerbated by the pandemic. Constriction in the workforce with business closures, earlier-than-planned retirements, changing recruitment pressures and the desire for hybrid work-at-home options added to the turnover and hiring pressures. While telehealth, remote monitoring and other uses of technology have helped, the technology cannot replace care provided directly for individuals.

Medicaid rates for most types of providers are not regularly adjusted for inflationary and environmental factors. From 2020-2022, the DeWine Administration and the Ohio General Assembly provided swift and targeted one-time relief payments to providers using several federal sources and some state GRF. Medicaid providers across the spectrum received provider relief: NFs, Behavioral Health, Hospitals, HCBS, ICF-IID and other groups of Medicaid providers, totaling more than $2.7 billion. While that relief was welcome, **it did not make a fundamental change to address wage pressures and the difficulty attracting individuals for essential positions.**

Since last summer as we were beginning preparations for this budget, I have been visited by a constant stream of literally every type of Medicaid provider, professional groups, associations, consumer and family organizations providing feedback about their needs. Rarely did anyone ask for less than a 30% rate increase, and requests equal to or greater than 50% were not uncommon. This is the same thing that I am hearing from Medicaid directors across the country.

Our responsibility to provide access to services is clear and the pressure to adapt to the changing workforce dynamics is real. To address this need in a structurally sound, fiscally responsible and sustainable way, the Administration is proposing a variety of targeted rate adjustments, using a combination of state GRF and one-time funds.

The budget proposes several rate increases in the following areas:

- Home and community based and community behavioral health services (details here),
- Pharmacy providers and other Medicaid non-institutional services (details here),
- Intermediate Care Facilities for Individuals with Intellectual or Other Developmental Disabilities (ICF-IID) and Nursing facility services.

The proposal also includes supports for hospitals GRF dollars but rather by the reinvestment of the current cost-coverage add-on program. With any rate adjustment it is important to considering the unique differences across the service delivery sectors and the differences in how services are reimbursed. Our goal is to establish some comparability across similar services or face the continuing challenge that waiver providers will move from one waiver to the other for higher pay, doing nothing

to retain or cultivate the needed workforce. We experienced this during the pandemic. While the ODM budget only addresses Medicaid funding, the various types of services and types of providers rely on Medicaid to varying degrees; with only some services allowable for payment under Medicare, commercial or employer sponsored insurance.

Home and community based and community behavioral health services. The budget proposes targeted increases in services that provide direct hands-on care to individuals.

- For HCBS services this includes nursing, personal care aide or homemaker personal care, adult day services and home delivered meals.
- While still not comparable to neighboring states, assisted living rates are increased and includes an add-on payment for the extra services required by someone with dementia or memory care.
- Community behavioral health services rates will be increased and a new mental health peer support service is being created. Both will be important to build out the system of care and contribute to the development of crisis response capacity.

Select Medicaid Non-Institutional Service and Pharmacy providers. In addition to a modest increase generally, dental and transportation services are targeted for significant rate increases. Forty percent of children between the ages of 3 and 17 on Medicaid had a dental appointment within the past year, compared to approximately 74% nationally. Feedback and concerns about access have been particularly significant with both dental and transportation services.

Intermediate Care Facilities for Individuals with Intellectual or Other Developmental Disabilities (ICF-IID) and Nursing Facility services. A modest increase is proposed to ensure individuals with intellectual and developmental disabilities (I/DD) have access to facility-based care by increasing the direct care component of the ICF reimbursement rate and increasing the daily rate for ICFs supporting people on ventilators. With regard to the rebasing and quality of nursing home services, this was addressed in the Governor's state of the state address.

The Importance of Waiver Alignment

This subcommittee has heard a great deal of testimony from providers of waiver services grateful for the Governor's proposal while seeking additional resources to stabilize access to long-term care services. Many of the questions I received in full Finance centered around how much it would take to increase direct care wages even more. We responded with a detailed breakdown to the Finance committee chair showing line-item by line-item what it would take to raise the wages beyond the proposed $16 per hour.

Each waiver is unique, not just in who they serve, but how they structure their reimbursement. This can make it challenging to compare apples-to-apples, but I can't stress how important it is that we make every effort to keep these waivers aligned as much as possible. While they may have different terminology and billing and coding procedures, at the end of the day they are providing similar services such as personal care, nursing, homemaking, adult day, home-delivered meals, and more.

If we pay more for one type of service in one waiver relative to another, then we run the risk of simply shifting providers away from one waiver to the other without actually adding any new providers to the system. We have been thoughtful and have collaborated with the Departments of Aging and Developmental Disabilities so we can raise the rates together instead of pitting the waivers against one another. We want to reiterate our willingness to provide any technical assistance to the General Assembly to keep the waiver rates aligned to accomplish that goal.

Closing

Medicaid plays a unique and necessary role for our state. We have the opportunity to positively change the trajectory of many young Ohioans' lives. We also have opportunities to lower barriers to employment for working age adults, and to ensure the full range of home and community-based options for Ohioans who are elderly or have a disability and wish to remain at home.

As Medicaid Director, I take very seriously the responsibility that the Governor and you have given me; for more than 3.5 million Ohioan's healthcare and the financial stewardship of this large program. The testimony you have heard in the past few weeks demonstrate the immense need we face to maintain access to vital services like dental and home care providers of services to those who are elderly, with physical disabilities or intellectual and other developmental disorders. We have worked incredibly hard to listen to the people we serve and the providers we work with in order to direct our resources where they are most needed. The achievements of the last few years could not have been accomplished without the partnership with the General Assembly, the Governor's leadership and amazing hard work by ODM staff, our new Next Generation managed care plan partners and all the vendors who have assisted us.

When we talk about truly making Ohio the best place to have and raise a family ***and*** helping every Ohioan achieve their God given potential, I believe that Medicaid is a cornerstone in making this a reality for many.

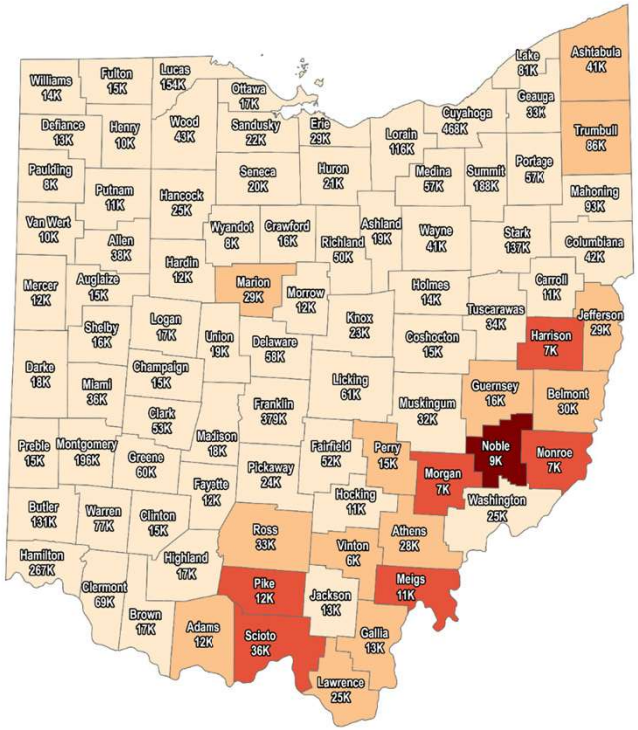
Thank you for the opportunity to provide an overview of our budget, Mr. Chairman. I'll be happy to answer any questions you may have.

Next Generation of Ohio Medicaid Managed Care

Next Generation of Ohio Medicaid Managed Care | Ohio Medicaid Managed Care

- **Provider**
  - Feb. 1 Launch Provider Placemat
  - Feb. 1 Launch Provider Help Desk One Pager
- **Member**
  - Feb. 1 Launch Member Placemat
  - Feb. 1 Launch Member Help Desk One Pager
- **Trading Partner**
  - Feb. 1 Launch Trading Partner Placemat
  - Feb. 1 Launch Trading Partner Help Desk Support Guide

Comparing Ohioans Unemployment Rates to Overall Medicaid Enrollment by County for Ages 18-64



Ohioans (16 - 64) Unemployed or Not in the Labor Force by County

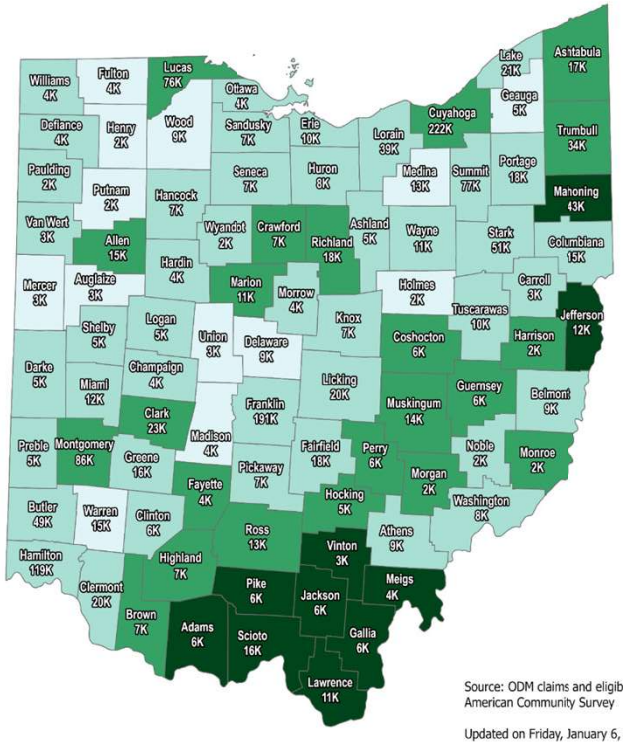
Ohioans ages 16 - 64 who are unemployed or not in the labor force as a percentage of all civilians ages 16 - 64 from the 2017 - 2021 ACS 5-year estimates (table B23001).

Note that ranges here are consistent with the ranges on the map titled, "Group VIII Population Not Working by County", for comparison.

Numbers displayed are the total estimated number (rounded to the next thousand) of Ohioans (16 - 64) unemployed or not in the labor force in each county.

% of Ohioans (16 - 64) Unemployed or Not in the Labor Force

- 35 - 50%
- 50 - 55%
- 55 - 60%
- 60 - 70%



MEDICAID-ENROLLED ADULTS (18 - 64) SFY 2022

Enrollment by County

Medicaid enrollment as a percentage of the total population ages 18 - 64 (ACS 2017-2021 5-year estimates) shown by county.

Numbers displayed are the total number (rounded to the nearest thousand) of Medicaid enrollees in each county.

- 7 - 15%
- 15 - 25%
- 25 - 30%
- 30 - 40%

Source: ODM claims and eligibility data from the EDW as of December 2022, American Community Survey

Updated on Friday, January 6, 2023

APPENDIX 1